

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0010660</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Carlyle Healthcare Center</u>		<b>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01-01-03</u> to <u>12-31-03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</b>	
<b>Address:</b> <u>501 Clinton Street</u> <u>Carlyle</u> <u>62231</u> Number City Zip Code		<b>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</b>	
<b>County:</b> <u>Clinton</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
<b>Telephone Number:</b> <u>618-594-3112</u> <b>Fax #</b> <u>618-594-2393</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) <u>David Reis</u> <u>President</u> (Firm Name & Address) <u>WDM Computer Services Inc.</u> <u>1900 Harrison Quincy, Ill 62301</u> (Telephone) <u>217-228-1950</u> <b>Fax #</b> <u>217-222-6053</u>	
<b>IDPA ID Number:</b> <u>37-0997048001</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
<b>Date of Initial License for Current Owners:</b> <u>04-01-1969</u>			
<b>Type of Ownership:</b>			
<input type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b> <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input checked="" type="checkbox"/> <b>PROPRIETARY</b> <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> <b>GOVERNMENTAL</b> <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Joann Brave</u> <b>Telephone Number:</b> <u>618-594-3112</u>			

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Carlyle Healthcare Center# 0010660 Report Period Beginning: 01-01-03 Ending: 12-31-03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>54</u>	Skilled (SNF)	<u>54</u>	<u>19,014</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>70</u>	Intermediate (ICF)	<u>70</u>	<u>25,086</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>124</u>	TOTALS	<u>124</u>	<u>44,100</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>17,258</u>		<u>2,426</u>	<u>19,684</u>	8
9	SNF/PED					9
10	ICF	<u>365</u>	<u>15,045</u>		<u>15,410</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>17,623</u>	<u>15,045</u>	<u>2,426</u>	<u>35,094</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 79.58%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 04-01-69

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 8 and days of care provided 2,426Medicare Intermediary Mutual of Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 2003 Fiscal Year: \_\_\_\_\_

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Carlyle Healthcare Center

# 0010660

Report Period Beginning: 01-01-03

Ending: 12-31-03

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	262,841	9,280	5,043	277,164		277,164		277,164			1
2	Food Purchase		164,938		164,938		164,938	(9,033)	155,905			2
3	Housekeeping	104,471	19,706		124,177		124,177		124,177			3
4	Laundry	76,910	19,193		96,103		96,103		96,103			4
5	Heat and Other Utilities			110,069	110,069		110,069		110,069			5
6	Maintenance	98,032	28,431	33,212	159,675		159,675		159,675			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	542,254	241,548	148,324	932,126		932,126	(9,033)	923,093			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	1,440,638	146,087	4,260	1,590,985		1,590,985	(8,050)	1,582,935			10
10a	Therapy	124,852	982	27,753	153,587		153,587		153,587			10a
11	Activities	81,441	10,001	24,312	115,754		115,754		115,754			11
12	Social Services	28,473		2,380	30,853		30,853		30,853			12
13	Nurse Aide Training											13
14	Program Transportation	1,538	397		1,935		1,935		1,935			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	1,676,942	157,467	62,305	1,896,714		1,896,714	(8,050)	1,888,664			16
	<b>C. General Administration</b>											
17	Administrative	170,140			170,140		170,140	(50,000)	120,140			17
18	Directors Fees											18
19	Professional Services			371,828	371,828		371,828	(291,842)	79,986			19
20	Dues, Fees, Subscriptions & Promotions			37,389	37,389		37,389	(30,117)	7,272			20
21	Clerical & General Office Expenses	104,011	13,314	17,064	134,389		134,389	577	134,966			21
22	Employee Benefits & Payroll Taxes			366,812	366,812		366,812	(6,349)	360,463			22
23	Inservice Training & Education			190	190		190		190			23
24	Travel and Seminar			5,340	5,340		5,340		5,340			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			93,501	93,501		93,501		93,501			26
27	Other (specify):* Sales Tax			4,128	4,128		4,128	(4,128)				27
28	<b>TOTAL General Administration</b>	274,151	13,314	896,252	1,183,717		1,183,717	(381,859)	801,858			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,493,347	412,329	1,106,881	4,012,557		4,012,557	(398,942)	3,613,615			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number Carlyle Healthcare Center

#0010660

Report Period Beginning:

01-01-03

Ending:

12-31-03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			123,562	123,562		123,562	(3,463)	120,099			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			25,314	25,314		25,314	(6,663)	18,651			32
33	Real Estate Taxes			30,000	30,000		30,000		30,000			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			828	828		828		828			35
36	Other (specify):* <b>Bad Debts</b>			526	526		526	(526)				36
37	<b>TOTAL Ownership</b>			180,230	180,230		180,230	(10,652)	169,578			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation	1,538	397		1,935		1,935	(1,928)	7			38
39	Ancillary Service Centers		146,561		146,561		146,561	(11,400)	135,161			39
40	Barber and Beauty Shops		13,362		13,362		13,362		13,362			40
41	Coffee and Gift Shops		14,032		14,032		14,032		14,032			41
42	Provider Participation Fee			65,266	65,266		65,266		65,266			42
43	Other (specify):* <b>Contributions</b>			1,525	1,525		1,525	(1,525)				43
44	<b>TOTAL Special Cost Centers</b>	1,538	174,352	66,791	242,681		242,681	(14,853)	227,828			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,494,885	586,681	1,353,902	4,435,468		4,435,468	(424,447)	4,011,021			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number Carlyle Healthcare Center

# 0010660

Report Period Beginning: 01-01-03

Ending: 12-31-03

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,543)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(8,050)	10		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(6,391)	30		9
10	Interest and Other Investment Income	(6,663)	32		10
11	Discounts, Allowances, Rebates & Refunds	(1,490)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,128)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,928)	38		16
17	Non-Care Related Fees	(50,978)	19		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,525)	43		20
21	Owner or Key-Man Insurance	(6,349)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(526)	36		24
25	Fund Raising, Advertising and Promotional	(30,222)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>Pham Billing</u>	(11,400)	39		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (137,193)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(288,795)		34
35	Other- Attach Schedule <u>Schedule XI</u>	1,541	30	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (287,254)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (424,447)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Carlyle Healthcare Center

ID# 0010660

Report Period Beginning: 01-01-03

Ending: 12-31-03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Carlyle Healthcare Center

# 0010660

Report Period Beginning:

01-01-03

Ending:

12-31-03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(9,033)	0	0	0	0	0	0	0	0	0	0	(9,033)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(9,033)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(9,033)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(8,050)	0	0	0	0	0	0	0	0	0	0	(8,050)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(8,050)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,050)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(50,000)	0	0	0	0	0	0	0	0	0	(50,000)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(50,978)	(240,864)	0	0	0	0	0	0	0	0	0	(291,842)	19
20	Fees, Subscriptions & Promotions	(30,222)	105	0	0	0	0	0	0	0	0	0	(30,117)	20
21	Clerical & General Office Expenses	0	577	0	0	0	0	0	0	0	0	0	577	21
22	Employee Benefits & Payroll Taxes	(6,349)	0	0	0	0	0	0	0	0	0	0	(6,349)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(4,128)	0	0	0	0	0	0	0	0	0	0	(4,128)	27
28	<b>TOTAL General Administration</b>	<b>(91,677)</b>	<b>(290,182)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(381,859)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(108,760)</b>	<b>(290,182)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(398,942)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Carlyle Healthcare Center# 0010660

Report Period Beginning:

01-01-03

Ending:

12-31-03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(4,850)	1,387	0	0	0	0	0	0	0	0	0	(3,463)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(6,663)	0	0	0	0	0	0	0	0	0	0	(6,663)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(526)	0	0	0	0	0	0	0	0	0	0	(526)	36
37	<b>TOTAL Ownership</b>	<b>(12,039)</b>	<b>1,387</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(10,652)</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	(1,928)	0	0	0	0	0	0	0	0	0	0	(1,928)	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,525)	0	0	0	0	0	0	0	0	0	0	(1,525)	43
44	<b>TOTAL Special Cost Centers</b>	<b>(3,453)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,453)</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(124,252)</b>	<b>(288,795)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(413,047)</b>	<b>45</b>



Facility Name &amp; ID Number Carlyle Healthcare Center

# 0010660

Report Period Beginning:

01-01-03

Ending:

12-31-03

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Dorothy Messick	51	St.Vincent's Home Inc.	Quincy	WDM Health Svcs	Quincy	Mgmt/Leasing
Ann reis	24	Clinton Manor	New Baden			
Sue Gray	24					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	30 Depreciation	\$	WDM Health service Leasing		\$ 1,387	\$ 1,387 1
2	V						2
3	V	19 Management	319,000	WDM Health Svcs/Mgmt		74,998	(244,002) 3
4	V	19 Accounting		WDM Health Svcs/Mgmt		3,138	3,138 4
5	V	21 office Supplies		WDM Health Svcs/Mgmt		577	577 5
6	V	20 Dues & Subscriptions		WDM Health Svcs/Mgmt		105	105 6
7	V						7
8	V						8
9	V	17 Officer Wages	100,000	St Vincents Allocation		50,000	(50,000) 9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 419,000			\$ 130,205	\$ * (288,795) 14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Carlyle Healthcare Center # 0010660 Report Period Beginning: 01-01-03 Ending: 12-31-03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Dorothy Messick	President		51.00		20	50.00	Wages	\$ 50,000	17-1	1
2	Ann Reis	Secretary		24.00		19	48.00				2
3	Sue Gray	Treasurer		24.00		20	50.00				3
4											4
5	Dorothy Messick	President	St.Vincent's			20	50.00				5
6	Ann Reis	Secretary	St.Vincent's			19	48.00				6
7	Sue Gray	Treasurer	St.Vincent's			20	50.00				7
8											8
9	Carlyle Healthcare owns St Vincent's			100.00					319,000	19-3	9
10	WDM Health Services		WDM Mgmt								10
11	Ann Reis		Clinton Manor	25.00		2	4.00				11
12											12
13								TOTAL	\$ 369,000		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Carlyle Healthcare Center# 0010660

Report Period Beginning:

01-01-03Ending: 12-31-03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization WDM Health Serv Inc.Street Address 1900 HarrisonCity / State / Zip Code Quincy, IL 62301Phone Number (217-228-1950)Fax Number (217-222-6053)

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19 Management Fees	Management Fees	427,000	2	\$ 100,000	\$ 100,000	319,000	\$ 74,707	1
2	19 Accounting Fees	Management Fees	427,000	2	4,200		319,000	3,138	2
3	21 Office Supplies	Management Fees	427,000	2	141		319,000	105	3
4	20 Dues & Subscriptions	Management Fees	427,000	2	723		319,000	540	4
5	20 License Fees	Management Fees	427,000	2	50		319,000	37	5
6	19 Legal	Management Fees	427,000	2	390		319,000	291	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 105,504	\$ 100,000		\$ 78,818	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	First National Bank		X	Mortgage	\$9,500.00	08-20-02	\$ 880,697	\$ 791,881	08-19-05	5.7500	\$ 25,314	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Investment Inyerest										(6,663)	6	
7												7	
8												8	
9	TOTAL Facility Related				\$9,500.00		\$ 880,697	\$ 791,881			\$ 18,651	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 880,697	\$ 791,881			\$ 18,651	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Carlyle Healthcare Center**# **0010660** Report Period Beginning: **01-01-03** Ending: **12-31-03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.		\$ <b>45,998</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ <b>42,606</b>	2
3. Under or (over) accrual (line 2 minus line 1).		\$ <b>(3,392)</b>	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>		\$ <b>45,993</b>	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ <b>*300000</b>	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998 <b>43,006</b>	8	
	1999 <b>41,760</b>	9	
	2000 <b>41,924</b>	10	
	2001 <b>41,978</b>	11	
	2002 <b>42,606</b>	12	
<b>*Reduced by 12606 allocated for Assisted Living</b>			
		<b>FOR OHF USE ONLY</b>	
		13 FROM R. E. TAX STATEMENT FOR 2002 \$	13
		14 PLUS APPEAL COST FROM LINE 5 \$	14
		15 LESS REFUND FROM LINE 6 \$	15
		16 AMOUNT TO USE FOR RATE CALCULATION \$	16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Carlyle Healthcare Center COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0010660

CONTACT PERSON REGARDING THIS REPORT Joann Brave

TELEPHONE 618-594-3112 FAX #: 618-594-2393

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>08-08-18-353-005</u>	<u>Nursung Home</u>	\$ <u>42,200.00</u>	\$ <u>42,200.00</u>
2. <u>08-08-18-353-004</u>	<u>Nursing Home</u>	\$ <u>405.00</u>	\$ <u>405.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>42,605.00</u></u>	\$ <u><u>42,605.00</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    X YES    \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A. Square Feet:

69,374

B. General Construction Type:

Exterior

Brick

Frame

Number of Stories

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☒

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Medical Clinic Building 2205 sq ft

Krebs Village 11112 sq ft 6 buildings

Assisted Living 8334 sq ft 12 units

No expenses are in schedule V as they are in separate divisions

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	48,738,720	1969	\$ 103,500	1
2					2
3	TOTALS	48,738,720		\$ 103,500	3

Facility Name &amp; ID Number Carlyle Healthcare Center

# 0010660

Report Period Beginning:

01-01-03

Ending:

12-31-03

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	44		1969	1969	\$ 30,426	\$	30	\$		\$ 30,426	4
5	4		1988	1988	99,400	3,313	30	3,313		49,976	5
6	1		1977	1977	21,293	716	30	716		19,025	6
7	25		1973	1973	138,148	389	30	389		138,148	7
8	3		1993	1993	399,471	13,360	30	13,360		146,743	8
	<b>Improvement Type**</b>										
9	42	BUILDING ADDTN		1974	183,451	6,193	30	6,193		180,871	9
10		GERIATIC CENTER		1975	15,496	522	30	522		14,972	10
11		REHAB CENTER		1978	10,750	358	30	358		9,315	11
12		SPRINKLER		1974	32,694		25			32,694	12
13		BUILDING IMPROVMT		1975	14,572		20			14,572	13
14		BUILDING IMPROVMT		1970	1,588		20			1,588	14
15		BUILDING IMPROVMT		1973	3,328		20			3,328	15
16		BUILDING IMPROVMT		1974	825		20			825	16
17		PLAN OF CORRECTN		1975	21,969		20			21,969	17
18		GUARDS		1980	1,379		8			1,379	18
19		ALARM SYSTEM		1980	1,200		8			1,200	19
20		BUILDING IMPVMT GARAGE		1984	12,050		15			12,050	20
21		LAND IMPROVMTS		1987	37,715	1,856	20	1,856		31,371	21
22		BUILDING IMPVMT		1988	30,824		20	1,541	1,541	23,628	22
23		BUILDING ADTN GLASS ENCLOSER		1986	319,491	10,650	30	10,650		182,820	23
24		ROOM REMODELING		1988	16,596	553	30	553		8,344	24
25		ROOM REMODELING		1989	1,948	65	30	65		972	25
26		WINDOWS		1989	3,230	108	30	108		1,582	26
27		ROOF		1989	11,294	384	30	384		5,535	27
28		SMOKE DET		1980	2,204		8			2,204	28
29		BUILDING IMPVMT		1993	4,932	42	10	42		4,932	29
30		HANDRAILS		1991	6,574		8			6,574	30
31		CUBICLE CURTAINS		1992	8,415		10			8,415	31
32		FRONT PORCH ADTN		1997	85,961	2,587	33	2,587		16,330	32
33		ELEVATOR		1997	83,288	4,164	20	4,164		25,333	33
34		LANDSCAPING/RAILING		1997	8,550	570	15	570		3,467	34
35		LAND IMPROVMTS		1993	51,227	3,441	15	3,441		35,229	35
36		ROOF REPAIR		1995	8,974	907	10	907		7,613	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	FLOOR TILE	1995	\$ 7,178	\$ 482	in Years	\$ 482	\$	\$ 3,847		37
38	FLOOR CORRECTION	1999	28,360	1,418	20	1,418		6,742		38
39	HALLWAY REMODELING	1999	10,315	1,032	15	1,032		4,728		39
40	NEW ROOF CTR/BOILER	2000	19,203	1,541	15	1,541		5,715		40
41	NEW GARAGE	2001	51,030	1,702	30	1,702		4,357		41
42	LANDSCAPING	2001	20,000	1,333	15	1,333		3,444		42
43	CONCRETE LOT/LIGHTING	2001	25,100	1,673	15	1,673		4,323		43
44	WINDOWS	2001	82,000	4,100	20	4,100		9,225		44
45	CENTER ROOF	2003	29,822	1,491	20	1,491		1,491		45
46	DINNING ROOM WINDOWS	2003	41,266	1,032	20	1,032		1,032		46
47	NEW PATIO	2003	73,579	3,356	20	3,356		3,356		47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 2,057,116	\$ 69,338		\$ 70,879	\$ 1,541	\$ 1,091,690		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 343,351	\$ 38,089	\$ 39,476	\$ 1,387		\$ 179,750	71
72	Current Year Purchases	88,988	5,322	5,322		8	5,322	72
73	Fully Depreciated Assets	77,309					77,309	73
74								74
75	TOTALS	\$ 509,648	\$ 43,411	\$ 44,798	\$ 1,387		\$ 262,381	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	Bus	1998	\$ 17,531	\$ 877	\$ 877		5	\$ 17,531	76
77	Facility	2000 Dodge Van	2001	17,724	3,545	3,545		5	10,043	77
78										78
79	Adm Auto		2001		6,391		(6,391)			79
80	TOTALS			\$ 35,255	\$ 10,813	\$ 4,422	\$ (6,391)		\$ 27,574	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,705,519	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 123,562	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 120,099	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (3,463)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,381,645	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Adm Auto	\$ 19,172	\$ 6,391	\$ 18,107	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 19,172	\$ 6,391	\$ 18,107	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 828

Description: Dishwasher

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ \_\_\_\_\_

13. /2005 \$ \_\_\_\_\_

14. /2006 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts				146,561		146,561	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Pharmacy Billing						(11,400)		(11,400)	13
14	TOTAL			\$		\$	\$ 135,161		\$ 135,161	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 239,584	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	524,713		3
4	Supply Inventory (priced at FIFO )	12,248		4
5	Short-Term Investments	686,104		5
6	Prepaid Insurance	39,229		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	<b>\$ 1,501,878</b>	<b>\$</b>	<b>10</b>
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	(104,578)		12
13	Land	128,950		13
14	Buildings, at Historical Cost	3,108,576		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	724,129		16
17	Accumulated Depreciation (book methods)	(1,944,973)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	<b>\$ 1,912,104</b>	<b>\$</b>	<b>24</b>
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	<b>\$ 3,413,982</b>	<b>\$</b>	<b>25</b>

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 48,219	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	151,590		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	47,788		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(22,955)		35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	<b>\$ 224,642</b>	<b>\$</b>	<b>38</b>
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable	791,881		40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	Deferred Income Trusts	60,995		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	<b>\$ 852,876</b>	<b>\$</b>	<b>45</b>
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	<b>\$ 1,077,518</b>	<b>\$</b>	<b>46</b>
47	<b>TOTAL EQUITY(page 18, line 24)</b>	<b>\$ 2,336,464</b>	<b>\$</b>	<b>47</b>
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	<b>\$ 3,413,982</b>	<b>\$</b>	<b>48</b>

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 2,545,984</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>2002 Income Tax Adjustemnts</b>	<b>(20,380)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 2,525,604</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(238,996)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe) <b>Other Divisions</b>	<b>49,856</b>	<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (189,140)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 2,336,464</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 3,718,328	1
2	Discounts and Allowances for all Levels	26,053	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 3,744,381	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	121,138	6
7	Oxygen	13,045	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 134,183	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education	3,050	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	11,457	12
13	Barber and Beauty Care	14,353	13
14	Non-Patient Meals	7,543	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	232,168	17
18	Sale of Supplies to Non-Patients	8,050	18
19	Laboratory	10,232	19
20	Radiology and X-Ray	6,212	20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 293,065	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	6,663	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 6,663	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Attached Schedule	18,180	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 18,180	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 4,196,472	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	932,126	31
32	Health Care	1,896,714	32
33	General Administration	1,183,717	33
	<b>B. Capital Expense</b>		
34	Ownership	180,230	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	177,415	35
36	Provider Participation Fee	65,266	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,435,468	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(238,996)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (238,996)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.



Facility Name &amp; ID Number Carlyle Healthcare Center

# 0010660

Report Period Beginning: 01-01-03

Ending:

12-31-03

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,036	2,092	\$ 47,194	\$ 22.56	1
2	Assistant Director of Nursing	1,873	2,177	43,487	19.98	2
3	Registered Nurses	10,437	11,162	204,668	18.34	3
4	Licensed Practical Nurses	23,320	24,591	396,300	16.12	4
5	Nurse Aides & Orderlies	71,942	75,769	748,989	9.89	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	8,737	9,197	124,852	13.58	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,415	1,566	18,970	12.11	9
10	Activity Assistants	6,902	7,375	62,471	8.47	10
11	Social Service Workers	1,983	2,191	28,473	13.00	11
12	Dietician					12
13	Food Service Supervisor	1,992	2,304	31,292	13.58	13
14	Head Cook	2,005	2,213	25,689	11.61	14
15	Cook Helpers/Assistants	18,968	20,488	171,266	8.36	15
16	Dishwashers	5,977	5,977	34,594	5.79	16
17	Maintenance Workers	7,537	7,913	98,032	12.39	17
18	Housekeepers	13,156	14,088	104,471	7.42	18
19	Laundry	9,207	9,823	76,910	7.83	19
20	Administrator	2,088	2,088	70,140	33.59	20
21	Assistant Administrator					21
22	Other Administrative	2,088	2,088	100,000	47.89	22
23	Office Manager	2,094	2,262	29,466	13.03	23
24	Clerical	5,754	6,050	74,545	12.32	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Transportation</u>	368	384	3,076	8.01	33
34	TOTAL (lines 1 - 33)	199,879	211,798	\$ 2,494,885 *	\$ 11.78	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	110	\$ 5,043	1-3	35
36	Medical Director		3,600	9-3	36
37	Medical Records Consultant		2,460	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	144	1,800	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	42	2,380	12-3	45
46	Other(specify) <u>Religious Services</u>		24,312	11-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	296	\$ 39,595		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description		Amount	Description		Amount		
Joann Brave	ADM		\$ 70,140	Workers' Compensation Insurance	\$	108,572	IDPH License Fee	\$	200		
Dorothy Messick	WK Officer	51	100,000	Unemployment Compensation Insurance		15,980	Advertising: Employee Recruitment		4,066		
	(see pg 6)			FICA Taxes		187,496	Health Care Worker Background Check				
				Employee Health Insurance		37,549	(Indicate # of checks performed 97 )		1,164		
				Employee Meals		1,453	Ill Sec of State		598		
				Illinois Municipal Retirement Fund (IMRF)*			Ill Dept of Public Health		70		
				401K Plan Expenses		8,237	Corp Fees		350		
				Officer Health/Life Ins		6,349	Subscriptions		720		
				Employee Physicals		1,176					
							Advertising		30,222		
TOTAL (agree to Schedule V, line 17, col. 1)							Less: Public Relations Expense	(			
(List each licensed administrator separately.)				\$	170,140		Non-allowable advertising		(30,222)		
B. Administrative - Other							Yellow page advertising	(			
Description			Amount	Non Allow		(6,349)					
			\$								
TOTAL (agree to Schedule V, line 17, col. 3)				\$			TOTAL (agree to Sch. V,		\$	7,168	
(Attach a copy of any management service agreement)							line 20, col. 8)				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees						G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description		Amount		
Herman Bodewes	Legal		\$ 1,850			\$	Out-of-State Travel	\$			
WDM Computer Serv Inc	Accounting		48,000								
	Consulting		2,978								
WDM Health Serv Inc.	Management		319,000				In-State Travel		5,340		
	see pg 6										
Non Allowable			(50,978)				Seminar Expense				
							Entertainment Expense	(			
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,				
(If total legal fees exceed \$2500 attach copy of invoices.)							line 24, col. 8)		\$	5,340	
							TOTAL				

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**  
**(See instructions.)**

[illegible]

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 8
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 13,637 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. \_\_\_\_\_
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. \_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 65,266  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. \_\_\_\_\_
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 1,453 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 7,543
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 1,928
- c. What percent of all travel expense relates to transportation of nurses and patients? 50
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? \_\_\_\_\_
- g. Does the facility transport residents to and from day training? N**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? N  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.